IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE INJECTAFER PRODUCTS LIABILITY LITIGATION **THIS DOCUMENT RELATES TO: ALL CASES**	**NO. 2:19-CV-00276-WB** **HON. WENDY BEETLESTONE**

ORDER

AND NOW, this 5th day of July 2022, upon consideration of the Plaintiff and Defendant Fact Sheets jointly submitted by the Parties, **IT IS ORDERED** that the Plaintiff Fact Sheet attached hereto as Exhibit A, and the Defendant Fact Sheet attached hereto as Exhibit B, are **APPROVED**.

BY THE COURT:

/s/Wendy Beetlestone, J.

WENDY BEETLESTONE, J.

EXHIBIT “A”

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE INJECTAFER PRODUCTS LIABILITY LITIGATION	NO. 2:19-cv-00276
	PLAINTIFF FACT SHEET

INSTRUCTIONS

1. The Plaintiff Fact Sheet ("PFS") must be answered by all Plaintiffs who are in the first bellwether eligible group for case workup in addition to the Plaintiff Profile Form that they previously answered.

2. Each question must be answered in full.

   - If you do not know or cannot recall the information, please indicate that in response to the question.
   - If you know part of the answer, please answer that part, and identify the parts you cannot answer.
   - Do not leave any blanks.
   - If there is not enough room on the form, attach as many sheets of paper as necessary to provide a complete answer.
   - When you are asked for a name and address, you are required to, 1) provide all of the information you have, even if only partial, and, 2) check reasonably available sources in order to provide the information.

3. You are providing this information based upon your current personal knowledge.

   - In responding to the PFS, you are not required to review the medical records that were collected for case investigation or litigation purposes.
   - You are not required to render a medical opinion or to speculate regarding conditions or diagnoses you do not understand or that are beyond your expertise.

I. CASE INFORMATION

A. Caption: _____

B. Docket Number: _____

C. Primary Attorney Contact: _____

II. PERSONAL INFORMATION

A. Current Full Name: _____

1. If someone other than the above-named person is completing this form, please state full name and relationship to the person named above: _____

B. Social Security Number: _____

C. List physical addresses for the past 10 years, month/years you resided there, names of those living with you and your relationship to that person (i.e. spouse, significant other, friend, mother, etc.):

Address	Dates Resided	Co-Residents

D. Have you ever been married? Yes ____ No _____

1. If yes, provide the names of and dates of marriage and divorce or death, if applicable, for each spouse.

_____
_____

E. Do you or have you ever had children? Yes ____ No _____

1. If yes, please provide the following information with respect to each child:

Full Name of Child	Month/Year of Birth	Is the child dependent on you?

F. Beginning with high school, identify the following for any schools that you have attended, even if you did not graduate or complete a program:

Name of School	Address	Dates of Attendance MM/YYYY	Degree Awarded, if any	Major or Primary Field of Study

G. Provide the following information for any employment over the past ten years through present. Only provide salary information if you are making or anticipate making a claim for lost wages:

Employer Name & Name of Supervisor	Addresses	Job Title / Description of Duties	Dates of Employment MM/YYYY	Salary / Rate of Pay

H. Have you ever served in any branch of the military? Yes ___ No ____

1. If yes, please provide the following information:

a. Branch and dates of service, rank upon discharges, and the type of discharge you received:

_____

_____

b. Were you discharged from the military at any time for any reason relating to a medical, physical, or psychological condition? Yes ____ No _____

1) If yes, state the condition:

_____

I. Within the last ten years, have you ever been convicted of, or pleaded guilty to, a felony and/or a crime of fraud or dishonesty? Yes ___ No ___

1. If yes, please provide the crime, the date of conviction, the jurisdiction/location of conviction, and if you were incarcerated, the length of incarceration.

_____

J. Have you been a party to a lawsuit in the past 10 years other than this case?

Yes ___ No ___

If yes, describe the nature of the case(s), the court(s) where it was filed, whether you were the plaintiff or defendant, and the name of your lawyer.

_____

K. Within the past ten years, have you ever filed a claim for or requested any type of benefits related to a short-term and/or long-term inability to work (either related or unrelated to any of the injuries or symptoms you allege are related to your case), including worker's compensation, Social Security disability, private disability insurance, or veteran's disability?

Yes ___ No ___

If yes, provide the following information for each type of claim:

Date filed or requested: _____

Name and address of company or agency where filed or requested: _____

_____

Nature of disability: _____

Granted ___ Denied ___

If granted, explain what you were awarded: _____

_____

If denied, explain why you were denied: _____

_____

Did you appeal your denial? Yes ___ No ___

If so, is that appeal still pending or what was the outcome? _____

_____

III. HEALTHCARE INFORMATION[1]

Identify the following:

A. To the extent a healthcare provider was not already identified on the Plaintiff Profile Form, list all healthcare providers from 7 years before your first use of Injectafer to present:

Name of provider and specialty	Address	Reason seen	Approximate date range

[1] Defendants reserve the right to seek additional medical records beyond the time periods referenced in this section.

B. All pharmacies (including online or mail order) from which you received prescription drugs from 7 years before your first use of Injectafer to present:

Name of pharmacy	Address	Approximate Date Range

C. All laboratories from which you've had blood drawn from 7 years before the first use of Injectafer to the present:

Name of laboratory	Address	Healthcare Provider Who Referred You	Approximate Date Range

D. Identify all medications (prescription and non-prescription), drugs (legal or illegal) and vitamins or supplements used from 7 years before you first used Injectafer to now.

Name of medication, drug, vitamin, or supplement	Approximate Dates	Name of prescriber, if any	Why you took it

Name of medication, drug, vitamin, or supplement	Approximate Dates	Name of prescriber, if any	Why you took it

E. At any time during 7 years before your first Injectafer prescription to the onset of your alleged injuries, did you practice any of the following specialty diets?

Vegetarian ____ Vegan ____ Pescatarian ___

Low Phosphorous ____ Keto/Low Carb ___

1. If yes to any of the above, did you do so at the recommendation or prescription by a healthcare provider?

Yes ___ No ___

a. If yes, please identify: _____

F. Beginning from 7 years before you first used Injectafer, have you suffered any chronic medical conditions or been under the regular care of a healthcare provider for any conditions other than anemia, iron deficiency, or another condition for which Injectafer was prescribed?

Yes ___ No ___

1. If yes, please describe: _____

_____

G. Do you have any blood related family members (defined here as blood-related parents, siblings, aunts/uncles, or grandparents) who have had hypophosphatemia (HPP)?

Yes ___ No ___ Unknown _____

1. If yes, please identify the person(s), their relation to you, and condition(s): _____

H. To the extent not already identified in the Plaintiff Profile Form, list all healthcare providers who have treated you for anemia, iron deficiency or any other underlying illness for which you took Injectafer.

Name of provider and office	Address	Specialty	Approximate Date Range

I. To the extent not already identified on the Plaintiff Profile Form, all hospitals, urgent care centers, clinics, infusion centers, or other healthcare facilities where you have received treatment either inpatient, outpatient, or in the emergency room from 7 years before your first use of Injectafer to present.

Name of Facility	Address	Reason for Treatment	Approx. Date Range	Referring Healthcare Provider, if any

J. Identify all mental health hospitals or facilities, psychiatrists, psychologists, counselors or others who treated you for mental health issues from 7 years before your first use of Injectafer to present.

Name	Address	Reason for Treatment	Approximate Date Range

K. All medical insurance carriers, including private and federal and/or state government based programs (Medicare, Medicaid, etc.), that you have used from 7 years before your first use of Injectafer to present.

Name	Address	Name of primary insured	Approximate Date Range

IV. IV IRON USE

A. When were you first diagnosed with the condition(s) for which your healthcare provider prescribed Injectafer to treat?

1. Which healthcare provider(s) initially diagnosed you with this condition? _____

B. Not including Injectafer, what iron treatments have you used (include pills, liquid and IV forms, and prescription and over-the-counter)?

Name of medicine	Approximate Dates	Who prescribed	Did you have side effects?

C. Have you ever had a blood transfusion from 7 years before your first use of Injectafer to present?

Yes ___ No ___

1. If yes, when and where (include all instances if more than one)?

_____

_____

D. Have you ever had any of the following?

Condition	Yes	No	Unknown
Hypophosphatemia or low levels of phosphorus in your blood			
Osteomalacia or other bone disorder			
Iron deficiency, iron deficiency anemia, anemia of chronic disease, or any other type of anemia			
Restless Leg Syndrome			
Pica (craving non-food items, such as ice or dirt)			
Vitamin or mineral deficiency (*e.g.*, Vitamin D, calcium, etc.)			
Alcohol use disorder/alcoholism			
Malnutrition or any other condition that affects absorption of nutrients			
Eating disorders (*e.g.*, anorexia, bulimia)			

Condition	Yes	No	Unknown
Feeding tube			
Bariatric surgery (includes various types of surgery for obesity such as gastric bypass)			
Hyperparathyroidism			
Sepsis			
Diabetes ketoacidosis			
Chronic kidney disease with dialysis, chronic kidney disease without dialysis, kidney transplant, and Fanconi syndrome			
Any medical condition that resulted in the use of any asthma medication(s)			
Respiratory alkalosis			
Lupus			
Inflammatory bowel disease, including Crohn's disease or Ulcerative Colitis			
Cancer			
Heavy uterine bleeding/menorrhagia, or severe postpartum or pregnancy related blood loss			

1. If you responded “yes” to any of the conditions listed above, provide the following information for each:

Condition	Healthcare provider who treated you	Approximate dates

V. CLAIM INFORMATION

A. For each of the physical injuries you are claiming in this lawsuit were caused by your use of Injectafer, indicate when each one started and stopped:

Injury	Date started	Date stopped

1. Had you ever experienced any of the physical injuries you are claiming in this lawsuit from 10 years before your first use of Injectafer?[2]

   Yes ____ No ____

   a. If yes, please list which injury, the dates you experienced the injury, and identify any healthcare provider and address from whom you sought treatment for that injury to the extent not previously provided above or in the Plaintiff Profile Form:

   _____

   _____

[2] Defendants reserve the right to seek additional medical records beyond the time period referenced in this question.

2. Has any healthcare provider told you that any of the injuries you are claiming in this lawsuit or any symptom thereof are the result of something other than Injectafer or that the cause is unknown?

   Yes _____ No _____

   a. If yes, please describe who told you, which alleged injuries or symptom, and when and what you were told:

   _____

   _____

B. Only if you are claiming psychological or emotional injuries, please describe those below. Describe the type of injury, the diagnosing and/or treating health care provider (if diagnosed and/or treated), any treatment you have undergone, the date of initial onset, and whether symptoms exist presently. If you are not claiming psychological or emotional injuries, put "N/A" below – do not leave it blank.

_____

_____

_____

_____

C. If you were diagnosed with hypophosphatemia (HPP):

1. When were you diagnosed?

   Date: _____ Not applicable: ____

2. When was the last time you had a below normal blood phosphorus level? _____

3. Have you discussed with any healthcare provider whether you are or are not at risk for having HPP in the future?

   Yes ___ No ____

   a. If yes, which healthcare provider(s)? _____

   b. What did they tell you? _____

D. Money Damages

1. If you are claiming medical expenses:

   a. State the total amount claimed: _____

   b. Describe how you calculated this number: _____

   _____

   _____

2. If you are claiming lost wages and/or lost earning capacity:

   a. State the total amount you are claiming: _____

   b. Describe how you calculated this number (*e.g.*, number of days off work times pay, etc.): _____

   _____

   _____

3. If you are claiming any other out-of-pocket expenses:

   a. State the total amount you are claiming: _____

   b. Describe how you calculated this number: _____

   _____

   _____

4. If you are claiming any other damages than those identified in D.1-3 above:

   a. Identify each additional category of damages you are seeking in this lawsuit, provide the monetary amount for any category of economic damages, and describe how you calculated any economic damages: _____

   _____

   _____

E. Only if your spouse is a Plaintiff making a claim for loss of consortium:

1. Spouse's name: _____

2. Spouse's date of birth: _____

3. Spouse's occupation for the last ten years: _____

4. Detailed description of Spouse's claim: _____

_____

VI. INJECTAFER

A. Did you see any written, televised or Internet-based advertising about Injectafer? (This question includes advertising by the drug manufacturer or attorneys.)

Yes ___ No ___ Do Not Recall ___

If yes, please describe what, where and approximately when you saw it (answering separately if more than one): _____

_____

_____

B. With the exception of any information provided in response to VI.A above, did you see anything else in writing (hard copy or electronic) about Injectafer before any of your injections? Yes ___ No ___ Do Not Recall _____

If yes, indicate whether you saw any of the following:

1. Injectafer labeling/Prescribing Information: Yes ___ No ___ Do Not Recall ____

2. Injectafer Patient Information: Yes ___ No ___ Do Not Recall ____

3. Internet articles, posts (including social media or blogs), or other online information:

Yes ___ No ___ Do Not Recall ____

4. Anything given to you by your healthcare provider or the infusion center: Yes ___ No ___ Do Not Recall ____

5. Other: Yes ___ No ___ Do Not Recall_____

If yes, please describe: _____

C. Did your healthcare provider(s) or the infusion center(s) tell you about potential side effects of Injectafer before any of your injections?

Yes ___ No ___ Do not Recall ____ If yes, please describe what they told you: _____

_____

D. Have you ever visited any websites, chat rooms, or other online groups about Injectafer? Yes ___ No ___ Do not Recall ___

If yes, please identify each of them and approximately when you visited:

_____

_____

VII. FACT WITNESSES

Please identify persons who you believe possess information concerning your claimed injuries and/or current medical condition (fact witnesses). You do not need to list healthcare providers who are already identified above or in the Plaintiff Profile Form.

Witness Name		**Relationship to you**	**Brief description of their knowledge**

VIII. AUTHORIZATIONS

Please sign and date the attached authorizations that are applicable to you. To the extent not previously provided, sign separate authorizations for each healthcare provider and facility identified above in Sections III.A-D, H-J. Make copies or request additional copies from your attorney if you need more than what is attached.

IX. DOCUMENTS

To the extent not already provided with the Plaintiff Profile Form or otherwise through discovery, please indicate whether you are in the possession of the following documents. If yes, please provide them to your attorney as soon as possible.

DOCUMENTS	Yes	No
Medical records in your possession corresponding to the healthcare providers and facilities identified above.		
Pharmacy records in your possession corresponding to the pharmacies, including online or mail order, identified above.		
If you have applied for disability benefits per section II.K, all records of the application or request and supporting documents, non-privileged communications between you/your representative and the entity where you applied, documentation of the final result, and all appeal related documents.		
Copies of medical insurance cards corresponding to those identified in response to section III.K.		
Medical insurance records (including Explanation of Benefits/EOB statements, bills, etc.) in your possession corresponding to those identified in response to section III.K.		
Education records in your possession corresponding to those identified in response to section II.F if you attended any of these institutions within 5 years prior to your Injectafer use and 6 months after your alleged injuries resolved.		
All non-privileged correspondence between you and any other person regarding Injectafer, including hard copy, electronic (such as emails or patient portal messages) and social media posts/communications of any kind.		
If you are claiming medical expenses in section V.D.1, copies of all medical bills, receipts, Explanation of Benefits (EOBs), and any other supporting documentation to the extent not already provided.		

DOCUMENTS	Yes	No
If you are claiming lost wages or loss of earning capacity in section V.D.1, employment records in your possession from 5 years before your first use of Injectafer to present and copies of all records to support your claim, including but not limited to, records or documents to or from your employer, and a signed authorization for your Social Security Earnings report (attached).		
If you are claiming lost wages or loss of earning capacity in section V.D.1, copies of your federal income tax returns from 5 years before your claimed injuries to present, and signed authorizations (attached) for obtaining them.		
All non-privileged diaries, journals, blogs, notes, calendars, or other hard copy or electronic writings or recordings by you about Injectafer, your claimed injuries, or the condition Injectafer was prescribed to treat.		
Any non-privileged electronically-stored information (including printouts of same) including electronic mail (e-mail), Internet postings or messages (including all forms of social media messages) to or from you regarding iron medications generally, Injectafer specifically or relating to your alleged injuries.		
All written, audio, television or video advertisements (including online) that you saw about Injectafer, including those by the manufacturer and those by attorneys.		
Photographs or audio or video recordings of you that you either believe are related to your Injectafer claim or that you intend to rely on to support your claim.		

VERIFICATION

I hereby verify that the facts set forth in the foregoing Plaintiff Fact Sheet are true and correct to the best of my knowledge, information, and belief. In understand these statements are subject to the penalties relating to unsworn falsification to authorities.

_____
Signature

_____
Printed Name

Date: _____

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164

To:_____

_____

I, the undersigned, hereby authorize and request the Custodian above-named entity to disclose to the agents or designees of Bowman and Brooke LLP and/or Sidley Austin LLP:

Discovery Resource
825 West 11th Street
Austin, TX 78701

any and all medical records, including those that may contain protected health information (PHI) regarding _____[First and last name], whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of Bowman and Brooke LLP and/or Sidley Austin LLP to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

all medical records, physician's records, surgeon's records, pathology/cytology reports, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, prescription records, medication records, orders for medications, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records. Copies ____/Originals____ of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy reports.

I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

The Medical Provider is not authorized to discuss any aspect of the above-named individual's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on the above-named individual's medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial.

Unless revoked in writing, this authorization shall expire two years after it is signed. The individual signing this authorization will be provided with a copy. The purpose of this authorization is for civil litigation. A copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **Information provided pursuant to this authorization shall be used only in connection with the litigation filed by the undersigned and as required by law, and shall not be used for any other purpose.**
- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing and provided to Bowman and Brooke LLP and Sidley Austin**

LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).

- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. The individual signing this authorization does not permit the disclosure or sale of his/her PHI for the purposes of marketing.**
- **The individual signing this authorization understands the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), as well as psychiatric care. It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **A notarized signature is not required per CFR §164.508. A copy of this authorization may be used in place of an original.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Bowman and Brooke LLP and/or Sidley Austin LLP and/or **their designees**

Name of Patient	Signature of Patient or Individual Representative
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority
Patient's Address	

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164

To:_____

_____

I, the undersigned, hereby authorize and request the Custodian above-named entity to disclose to the agents or designees of Bowman and Brooke LLP and/or Sidley Austin LLP:

Discovery Resource
825 West 11th Street
Austin, TX 78701

any and all medical records, including those that may contain protected health information (PHI) regarding _____[First and last name], whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of Bowman and Brooke LLP and/or Sidley Austin LLP to copy, inspect and review any and all such records. Records requested include:

Counseling or treatment for any emotional health or mental health issue, including psychotherapy notes as defined by 25 CFR § 164.501: "Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."

I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

The Medical Provider is not authorized to discuss any aspect of the above-named individual's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on the above-named individual's medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial.

Unless revoked in writing, this authorization shall expire two years after it is signed. The individual signing this authorization will be provided with a copy. The purpose of this authorization is for civil litigation. A copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- **Information provided pursuant to this authorization shall be used only in connection with the litigation filed by the undersigned and as required by law, and shall not be used for any other purpose.**
- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing and provided to Bowman and Brooke LLP and Sidley Austin**

LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).

- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. The individual signing this authorization does not permit the disclosure or sale of his/her PHI for the purposes of marketing.**
- **The individual signing this authorization understands the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), as well as psychiatric care. It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **A notarized signature is not required per CFR §164.508. A copy of this authorization may be used in place of an original.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Bowman and Brooke LLP and/or Sidley Austin LLP and/or **their designees.**

Name of Patient	Signature of Patient or Individual Representative
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority
Patient's Address	

CVS Pharmacy DISCLOSURE AUTHORIZATION FORM
One CVS Drive, Woonsocket, RI 02895
Fax (401) 652-1593

PATIENT REQUESTING DISCLOSURE

Name: _____
Address: _____
Address: _____
Date of Birth _____

I hereby authorize CVS Pharmacy to disclose my Patient Prescription Record (PPR), reflecting my prescription history and any other pharmacy services I have received from CVS Pharmacy as set forth below:

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s) categories of person or entities:
   Name: Bowman and Brooke LLP and/or its agent, Discovery Resource
   Address: 825 West 11th Street, Austin, TX 78701
   Address: _____

2. Purpose of the release of this information

   ☐ At the request of Patient/Patient's personal representative.
   ☒ Other: Legal/litigation

3. I understand that my PPR may include information related to treatment of mental health condition, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases. I understand that the information, if any, pertaining to any of the conditions described above may be released.

   ☐ I authorize the release of this information.
   ☐ I do not authorize the release of this information.

4. I understand that I may cancel this authorization at any time by writing to CVS Pharmacy Privacy Office, One CVS Drive Woonsocket, RI 02895, or fax to 401-765-9304, except to the extent that CVS Pharmacy has taken action in reliance on this authorization.

5. I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment from the CVS Pharmacy, any payment for treatment or enrollment or eligibility for benefits. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.

6. I understand that if the person or entity that receives my PPR is not required to comply with the applicable privacy regulations, the information described above may be redisclosed by the recipient and no longer be protected by those regulations.

7. I understand that I have the right to receive a copy of this Authorization.

8. This authorization will expire 6 months from the date I sign it as shown below on this authorization unless I enter a different expiration date here _____.

_____ _____
Signature of Patient or Personal Representative * Date

*If signed by someone other than the patient, please explain your authority to act on behalf of the patient: _____

EXPRESS SCRIPTS®

Authorization to Use and Disclose Health Information

PLEASE PRINT CLEARLY

Patient's Name: _____ ID Number_____

Address: _____ SSN: _____
Street

_____ Date of Birth: _____/_____/_____
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

[ ] Check here if Plan Sponsor is Department of Defense

I authorize Express Scripts, Inc. or one of its subsidiaries or affiliates to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
   [X] PBM Prescription Claims Information
   [ ] Only Mail Order Pharmacy Records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):

   Legal/Litigation

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

   Name: Bowman and Brooke LLP and/or its agent Discovery Resource

   Address: 825 West 11th Street, Austin, TX 78701

   E-mail Address _____

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed by Express Scripts, Inc. once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

   Express Scripts, Inc.
   Claims Dept – Records/B402-01
   8931 Springdale Avenue
   St. Louis, MO 63134
   FAX: 866-254-2313

8. I understand that I have a right to request and receive a copy of Express Scripts' Notice of Privacy Practices at www.express-scripts.com.

9. A photocopy of this authorization is as valid as the original.

10. I understand that this authorization will expire ten (10) years from the date signed below.

SIGNATURE

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following and attach supporting documentation:

Relationship to patient: _____

Authority to act for the patient:_____

Prescription Claims Information is readily available for the previous ten years. Patients wanting prescription claim information sent to the address on file should call the number on the back of the prescription identification card

Members wanting PBM Prescription Claim Information sent to the address on file free of charge should call the number on the back of the prescription identification card. The Express Scripts website also provides all members the ability to access and print PBM Prescription Claim Information for free for the last 24 months of service by logging into www.express-scripts.com.

Please return the completed form to the address below. For those requests for PBM Prescription Claims Information not submitted by a member's legal personal representative, please also submit a check or money order for the non-refundable fee of $90.00.

Express Scripts, Inc.
Claims Dept – Records/B402-01
8931 Springdale Avenue
St. Louis MO 63134
Fax 866-254-2313

Email: Prescriptionhistoryrequests@express-scripts.com

Please allow 6-8 weeks for the request to be processed. For questions or concerns, please call toll-free 800-332-5455, ext 326584.

Pharmacy and Health-Related Services:
Authorization to Use and Disclose Health Information

Name of Patient/Individual: _____ Date of Birth: _____

Address: _____ Daytime Phone: _____

Store Names: Giant Eagle Store Addresses: _____

I authorize the use or disclosure of my health information, as described below.

Description of health information that may be used and/or disclosed:

☒ Prescription information for the following time period: _____

☐ Lab values and any other information related to diabetes/diabetic-related conditions

☐ Other (please describe): _____

_____

I understand that this health information may include HIV-related information and/or information relating to substance abuse treatment and/or mental health diagnoses and treatment and that by signing this form, I am authorizing such information to be disclosed.

Check and complete one or both of the following:

1. ☒ I authorize the pharmacies identified above to disclose the information described above to:
Bowman and Brooke LLP and/or its agent, Discovery Resource

and I authorize that person or organization to use the information for the following purpose(s):

☐ At the request of the individual
☒ Other (describe): Legal/Litigation

_____

2. ☐ I authorize the pharmacies identified above to request the information described above from:

_____

and to use the information described above for the following purpose(s):

☐ At the request of the individual
☐ To evaluate and plan for the care of diabetes and related conditions
☐ Other (describe): _____

_____

I understand that, if the person or entity that receives the information is not a health care provider or health plan covered by the HIPAA Privacy Rule, the information used or disclosed as described above may be redisclosed to others and no longer protected. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I may revoke this Authorization in writing at any time, except to the extent that the pharmacies identified above have already taken action in reliance on this Authorization, by submitting a written statement of revocation to: Manager of Pharmacy Compliance, c/o Ahold USA, Inc., 1149 Harrisburg Pike, Carlisle, PA 17013.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

Expiration:

This Authorization will expire on the following date or upon the occurrence of the following event: _____. (In Maryland, your authorization will only be valid for one year unless you are a nursing home resident; to the extent the information to be disclosed includes mental health information, in the District of Columbia your authorization will only be valid for sixty days.).

By signing below, I acknowledge that I have read and understand this Authorization form.

_____ _____

Signature of Patient or Patient's Representative | Date

If signed by the Patient's Representative, please print name and describe relationship to the patient or other authority to act:

_____ _____

Name | Relationship to Patient

☐ *Check here if you would like a copy of this Authorization form mailed to you*

OPTUMRx®

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

OptumRx®, on behalf of itself and affiliated companies, uses this form to get your permission to use and/or disclose your protected health information (PHI) to your authorized representative. This authorization does not allow your authorized representative to make any of your treatment decisions or direct care decisions. If you want help with your health care and treatment decisions, you must get additional legal documentation.

Use this form to request authorization for the release of PHI, including patient profile or prescription records, to your authorized representative(s) named in Section 2 below. When filling out this form, provide your most current information.

1 Member information (please provide current information)

Last Name	First Name	MI

Mailing Street Address	Apt. #

City	State	ZIP

Member ID Number

Date of Birth (mm/dd/yyyy) | Phone Number with Area Code

2 Authorized representative's information

I authorize OptumRx to use and disclose my PHI to the person(s) or organization(s) named below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my authorized representative is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by my authorized representative without my permission.

Authorized representative #1

Name	Phone Number with Area Code
Bowman and Brooke LLP and/or its agent Discovery Resource	512-329-8080

Mailing Street Address	Apt. #
825 West 11th Street	

City	State	ZIP
Austin	Texas	78701

Relationship to Member
Agent of Bowman and Brooke LLP, opposing counsel in legal suit

Authorized representative #2

Name	Phone Number with Area Code

Mailing Street Address	Apt. #

City	State	ZIP

Relationship to Member

3 Description of information to use or disclose

Please describe the information covered by this authorization.

I understand that by leaving this section blank, I am authorizing the disclosure of all of my PHI, including my patient profile and pharmaceutical records, to my authorized representative(s).

Description:

4 Purpose of disclosure

The purpose of this authorization is to assist me in receiving my health plan benefits and make payments for my health plan benefits. If there are other purposes or reasons for this authorization, they are provided below.

Purpose: Legal suit

5 Expiration and revocation

I understand that I have the right to end this authorization at any time. I understand that if I do not wish the person(s) named in Section 2 to remain my authorized representative, I must cancel this authorization **in writing** and send such notice to the address listed below. I understand that a cancellation of this authorization has no effect on disclosures or uses of PHI by OptumRx before receiving my cancellation notice.

I understand that this authorization will expire on (insert date):_____ . If I do not provide an expiration date, I am aware that this authorization is valid for sixty (60) months from the date of my signature as noted below.

6 Authorization and signature of individual or individual's LEGAL representative

I have read and understand the content of this Authorization to Use and Disclose PHI. This authorization correctly describes my request of OptumRx. I understand that by signing this form, I am voluntarily giving my permission for OptumRx to use and/or disclose my PHI to the person(s) named in Section 2. Any services otherwise provided to me by OptumRx will not be affected by my decision to provide this authorization. I may refuse to sign, and OptumRx will not condition my treatment, payment, enrollment or eligibility for benefits on my decision to sign or not sign this authorization.

X _____ _____
Member Signature Date

X _____ _____
Witness Signature Date
(A witness signature is only needed if the member is unable to sign or the witness is an interpreter)

If this authorization is signed on the member's behalf by his/her legal representative, please **attach documentation of legal representative designation and complete the following:**

Legal Representative's Name		Date	
Mailing Street Address			Apt. #
City	State	ZIP	
Relationship to Member			

7 Please mail the completed form to: OptumRx,Attn: Commitment and Follow Up Team, 6860 West 115th Street, Mail Stop: KS015-1000, Overland Park, KS 66211-2457 or fax to 1-866-889-2116.

Please keep a copy of this form for your records. You also have the right to receive a copy of this authorization.

Attorney Authorization

I authorize Rite Aid to disclose medical information at my request that it maintains to-Bowman and Brooke LLP and/or its agent Discovery Resource **(name of law firm)** for use in my legal representation. This Authorization includes any and all information Rite Aid may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy data and EKG's.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.

This authorization will expire one year from the date of my signature as indicated below.

I understand that Rite Aid may not disclose my information as requested above without my signature on this Authorization and that my signing or refusing to sign this Authorization will not affect my ability to receive treatment, payment or health care operations from Rite Aid.

I understand that I have the right to revoke this authorization in writing at any time prior to the expiration date by sending my written revocation to **Rite Aid, Legal Department, P. O. Box 3165, Harrisburg, PA 17105**. Any actions based on this authorization that Rite Aid may have taken prior to their receiving notice of my revocation will be considered validly authorized.

Patient's Name _____
Patient's Date of Birth _____
Patient's Social Security Number_____

Date_____ Signature _____
Printed Name_____

IF PERSON OTHER THAN THE PATIENT SIGNED THIS AUTHORIZATION, PLEASE INDICATE RELATIONSHIP BELOW AND PROVIDE PROPER DOCUMENTATION:

Power of Attorney _____ **Parent or Guardian _____**

Court Appointed _____ **Other (Please Explain) _____**

Walgreens

AUTHORIZATION – FOR RELEASE OF INFORMATION TO THIRD PARTY

This Authorization is for use, pursuant to the HIPAA privacy rules, if you are authorizing the release of medical/health information to a third party, such as a housing authority, insurance company, or law office. You understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

Section 1: Patient's printed information

Last name | First name | MI

DOB

Street address

City | State | Zip code

Telephone

Email address

List the location you obtain most of your prescriptions: _____

Section 2: Person authorized to receive information

Last name: DISCOVERY | First name: RESOURCE | MI:

Street address: 825 W 11th STREET

City: AUSTIN | State: TX | Zip code: 78701

Telephone: (713) 223-3300

Email address:

Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Caregiver ☒ Other (list): OPPOSING COUNSEL VENDOR

Section 3: Describe or list the information that you are asking us to release

MEDICAL RECORDS

PHARMACY RECORDS

Walgreens

Section 4: List the specific purpose for requesting this information

L	E	G	A	L																					

Section 5: Expiration required (see instructions)

This authorization expires: ☐☐/☐☐/☐☐☐☐ or event: _____

For Maryland residents only: This Authorization will expire one year from the date listed below in Section 7.

Section 6: Information regarding this Authorization

- You have the right to revoke this Authorization, in writing to the Privacy Office, at any time. The revocation is only effective after it is received and logged by the Privacy Office. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative to include a description of that person's ability to act on behalf of the patient.

Section 7: Signature

I, _____, by signing below, authorize Walgreens to use or disclose my protected health information as described above.

_____ ☐☐/☐☐/☐☐☐☐

Signature Date

Section 8: If this Authorization is signed by the patient's personal representative, please explain your authority to act (see instructions for additional information that may be required)

_____

Section 9: Mail this completed and signed form to: Walgreens Custodian of Records, 1901 East Voorhees St., MS 735, Danville, Illinois 61834; Phone: (217) 554-8949; Fax: (217) 554-8955.

Authorization to Release Private Health Information

Walmart
Save money. Live better.

Legal

HIPAA Team

702 SW 8th Street
Bentonville, AR 72716-0215
Phone 479.273.4505
Fax 479.204.9655
rxlegal@walmartlegal.com

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Requestor and Purpose (If to be released to patient check here ☐ and continue with Section 3)

Individual or Entity: BOWMAN AND BROOK LLP OR ITS'	Person Receiving Information: AUTHORIZED AGENT, DISCOVERY RESOURCE		
Address: 825 WEST 11TH STREET			
City: AUSTIN	State: TX	Zip: 78701	Phone: 512-329-8080

Purpose of Release: ☐ Patient Request ☒ Legal/Attorney Letter ☐ Insurance ☐ Housing

Section 3: Information to be Released (Check All That Apply)

I authorize Walmart to release of the following health information:
☐ Medical Expenses Summary (List of all prescriptions with expense information)
☒ Designated Record Set (Entire medical record maintained by the pharmacy)
☐ Specific Prescription(s): _____
☐ One Line Summary (total number of prescriptions and out-of-pocket expenses)

For the following dates of service:
☐ All dates of service ☒ From _____ to _____

From the following facilities:
☒ All locations where I have had prescriptions filled
☐ Only the following location(s) (include city and state): _____

Section 4: Expiration Date or Event

This authorization will remain in effect
☐ Until the following date: _____
☒ Until the following event occurs: THE CONCLUSION OF THE LITIGATION.
☐ Until one year from the date of my signature below.

Section 5: Understandings

(a) I understand that signing this authorization is voluntary. Receipt of pharmacy services will not be conditioned upon my authorization of this disclosure. (45 C.F.R. 164.508(c)(2)(ii))

(b) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws. (45 C.F.R. 164.508(c)(2)(iii))

(c) I have the right to revoke this authorization in writing at any time by notifying the Walmart Legal Department. The revocation will not apply to the extent that (i) Walmart has already released health information based on this authorization or (ii) this authorization was obtained as a condition to the patient obtaining insurance or for an insurer to contest a claim. (45 C.F.R. 164.508(c)(2)(i))

(d) I understand that by signing below I authorize the release of records that may include: HIV/AIDS related information and or records; Mental Health Information and or records; Drug/Alcohol Diagnosis and Treatment Information; Pregnancy and Family Planning Information; Sexually Transmitted Disease Information.

Section 6: Signature and Date

_____ _____
Signature of Patient or Personal Representative Date

If you have signed this as a legally authorized representative of the patient, please print your name and relationship to the patient below. If your relationship is anything other than parent of a minor, please include documentation of your authority to sign for the patient's records.

_____ _____
Name of Personal Representative (please print) **Relationship to Patient (parent, guardian, etc.)**

KAISER PERMANENTE®

(*Kaiser Permanente entities are listed on reverse side of this form)

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____

Medical Record number: _____ Birth Date: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone #: ( ) _____

Email: _____

Kaiser Permanente may release this information to: ☐ Check if same as above

Recipient Name: Bowman and Brooke LLP and/or its authorized agent, Discovery Resource

Address: 825 W. 11th Street City: Austin State: TX Zip Code: 78701

Phone # (512) 329-8080 Email: _____

This disclosure can be used for the following purpose(s): ☐ Personal Use ☒ Legal ☐ Insurance
☐ Medical Treatment ☐ Medical Condition Verification ☐ Disability ☐ FMLA ☐ Workers' Comp

Check ONLY one of the following three options to identify the health information to be released.

☐ **Option 1:** Form Completion (a substitute form or relevant medical records may be released)

☐ **Option 2:** Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records

☒ **Option 3:** Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: _____

Step 2. Select types of records to be released:

☒ KP Medical Office ☒ Kaiser Foundation Hospital ☒ Immunization ☒ Lab Results
☒ Diagnostic Images ☒ Copays & Deductibles ☒ Itemized Billing ☒ Pharmacy
☐ Other (provider, department, specialty): _____

NOTE: Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions.

Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.

☐ **Mental Health Treatment Records** ☐ **Addiction Medicine Treatment Records** ☐ **HIV Test Results**

Media Type: ☒ Electronic ☐ Paper **Delivery Preference:** ☒ Electronic ☐ Mail ☐ Pickup

DURATION: Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.

REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

Date _____ Signature _____ If personal representative, print name/relationship _____

"Kaiser Permanente" means both your insurance company (a Kaiser Permanente health plan) and your doctors (a Permanente medical or dental group). It also includes different groups depending on where you live.

All states where we do business:
• Kaiser Foundation Hospitals

California:
• Kaiser Foundation Health Plan, Inc., Northern California Region
• The Permanente Medical Group

• Kaiser Foundation Health Plan, Inc., Southern California Region
• Southern California Permanente Medical Group

Colorado:
• Kaiser Foundation Health Plan of Colorado
• Colorado Permanente Medical Group, P.C.

Georgia:
• Kaiser Foundation Health Plan of Georgia, Inc.
• The Southeast Permanente Medical Group, Inc.

Hawaii:
• Kaiser Foundation Health Plan, Inc., Hawaii Region
• Hawaii Permanente Medical Group, Inc.

Mid-Atlantic States:
• Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
• Mid-Atlantic Permanente Medical Group, P.C.

Northwest:
• Kaiser Foundation Health Plan of the Northwest
• Northwest Permanente, P.C.
• Permanente Dental Associates, P.C.

Form **4506**

(Novmeber 2021)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested**. Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ 43.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____ _____
Print/Type name **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

▶ _____
Print/Type name

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

Form **SSA-7050-F4** (02-2021)
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**
   Includes periods of employment or self-employment and the names and addresses of employers.

2. **Certified Yearly Totals of Earnings**
   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are free to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, allows us to collect this information. In addition, the Budget and Accounting Act of 1950 and Debt Collection Act of 1982 authorize us to collect credit card information, if you choose to pay for the earnings information you have requested with a credit card. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from processing your request.

We will use the information to identify your records, process your request, and send the earnings information you request. We may also share the information for the following purposes, called routine uses:

1. To the Internal Revenue Service (IRS) for auditing SSA's compliance with the safeguard provisions of the Internal Revenue Code of 1986, as amended.

2. To contractors and other Federal agencies, as necessary, for the purpose of, assisting the Social Security Administration (SSA) in the efficient administration of its programs.

3. To banks enrolled in the Treasury credit card network to collect a payment or debt when the individual has given his/her credit card number for this purpose.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System, 60-0090, entitled Master Beneficiary Record, 60-0224, entitled SSA-Initiated Personal Earnings and Benefit Estimate Statement, and 60-0231, entitled Financial Transactions of SSA Accounting and Finance Offices. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $92.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $30.00 fee.

☐ **Certified Yearly Totals of Earnings $30.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name

Address | State

City | ZIP Code

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual).
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature AND Printed Name of Individual or Legal Guardian | *SSA must receive this form within 120 days from the date signed*
Date

Relationship (if applicable, you must attach proof) | Daytime Phone:

Address | State

City | ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for one ONE Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $92.00 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request Itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $30.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $30.00 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011	If using private contractor such as FedEx mail form, supporting documentation, and application fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$92.00	$122.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $30.00. You may obtain non-certified yearly totals FREE of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	Area Code
Credit Card Number	
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $30.00, $92.00, or $122.00. SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	Date

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
Bowman and Brooke LLP	825 West 11th Street, Austin TX 78701
and/or its authorized agent, Discovery Resour	

***I want this information released because:** Litigation

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Consultive exams, award/denial notices, benefit applications, appeals, questionnaires, doc

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

EXHIBIT “B”

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE; INJECTAFER PRODUCTS LIABILITY LITIGATION	NO. 2:19-cv-00276

DEFENDANT FACT SHEET

For each filed case, Defendants American Regent, Inc. (ARI) Daiichi Sankyo, Inc. and Daiichi Sankyo US Holdings, Inc., (collectively, DSI) and Vifor International AG (Vifor) must each complete this Defendant Fact Sheet ("DFS") and produce documents, in accordance with Order No. XX. This DFS shall supplement the information previously provided with ARI and DSI's Defendant Profile Forms ("DPF") completed in accordance with Case Management Order No. 3, but ARI and DSI must still supplement their DPF if either Defendant learns that the DPF is incomplete or incorrect.

In completing this DFS, each Defendant shall provide information that is true and correct to the best of each Defendant's knowledge and upon good faith investigation. Each Defendant shall identify any documents produced in response to a question or request herein by document number or Bates range, shall supplement responses if Defendant learns that they are incomplete or incorrect, and may attach additional sheets of paper as necessary.

Definitions:

"Responding defendant" shall refer to the Defendant responding to this DFS as identified in Section I A, and any officers, agents, employees, vendors, representatives, or others acting on their behalf.

"Ferric carboxymaltose," or "FCM", shall refer to the iron replacement product administered directly into the vein to treat adults with iron deficiency anemia, known by the brand name of Injectafer® in the United States (and Ferinject® outside the United States).

"Plaintiff" means the party filing a lawsuit and alleging an injury relating to use of Injectafer. "Document" shall refer to "any designated documents or electronically stored information – including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data complications – stored in any medium from which information can be obtained either directly or, if necessary, after translation by the responding party into a reasonably useable form," in Defendants' possession, custody, or control, and consistent with Fed. R. Civ. P. 34(a)(1)(A).

I. CASE INFORMATION

A. This DFS is submitted by Defendant _____

B. This DFS pertains to:

Case caption: _____

Civil Action No.: _____

II. INFORMATION REGARDING PLAINTIFF'S HEALTHCARE PROVIDERS

A. To the extent not already provided in the DPF, indicate if the Prescribing Healthcare Provider(s) identified in section III of the Plaintiff Fact Sheet ("PFS") or the Treating Healthcare Provider(s) identified by Plaintiff in Section VI of the Plaintiff Profile Form ("PPF")

1. Contacted the responding Defendant or been contacted by the responding Defendant via phone call, in-person contact, or in writing through the call or contact centers, the medical affairs or pharmacovigilance employees, or the custodians already identified in this case, from five years before Plaintiff's first Injectafer prescription through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF, regarding ferric carboxymaltose. Yes ___ No ___

If yes, to the extent not previously provided in the DPF, identify the Healthcare Provider(s), the date(s) of contact, the name, title, and employer of the recipient of the contact from the Healthcare Provider or the name, title, and employer of the individual who contacted the Healthcare Provider, the nature of the contact, and whether a response was sent. To the extent not previously produced and identified with the DPF, produce and identify any documents related to this contact.

2. Attended Continuing Medical Education courses, conferences, or other presentations that were sponsored or organized in full or in part by the responding Defendant in which ferric carboxymaltose, or hypophosphatemia and/or osteomalacia, was specifically discussed, from five years before Plaintiff's first Injectafer prescription through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF. Yes ___ No ___

If yes, to the extent not previously provided in the DPF, identify the Healthcare Provider(s), the date of attendance, and the name and the location of the course, conference, or other presentation. To the extent not previously produced and identified with the DPF, produce any documents presented or provided at the presentation by the responding Defendant as well as any speakers' notes associated with responding Defendant.

3. Served as a clinical investigator, advisory board participant, key opinion leader, speaker, or consultant for the responding Defendant, from five years before Plaintiff's first FCM prescription to present.
Yes____ No_____

If yes, to the extent not previously provided in the DPF, identify the Healthcare Provider(s), the date(s) the Healthcare Provider was consulted, retained, and/or compensated, the nature of the affiliation, and state the amount of compensation. To the extent not previously produced with the DPF, produce any contracts, agreements to participate, non-disclosure agreements, or correspondence with each Healthcare Provider(s) related to said contracts, agreements to participate, non-disclosure agreements, identifying which document relates to which Healthcare Provider(s).

4. Been sent, shown, given, or provided by responding Defendants marketing, promotional, advertising materials, or other literature regarding FCM from five years before Plaintiff's first Injectafer prescription through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF, regarding ferric carboxymaltose. Yes ___ No ___

If yes, to the extent not previously provided in the DPF, identify the Healthcare Provider(s), the individual who sent, showed, or provided the documents to the Healthcare Provider and the title and company for whom that individual worked, the date the documents were shown or provided, and the method of contact. To the extent not previously produced and identified with the DPF, produce and identify all responsive documents.

B. To the extent not already provided in the DPF, as to responding Defendants ARI and DSI only, for the Prescribing Healthcare Provider(s) identified in Section III or the Treating Healthcare Provider(s) in Section VI of the Plaintiff Profile Form ("PPF"):

1. Identify by name and employer all Sales or Detail Representatives, Medical Science Liaisons ("MSLs"), or Tele-detailer(s) who were employed or contracted by or on behalf of the responding Defendant and who contacted the Healthcare Provider in person, in writing, or via the phone or via tele-detailing regarding FCM in the five years before Plaintiff's first FCM prescription

through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF, regarding ferric carboxymaltose.

2. Identify by name and employer the Territory Manager(s), District Manager(s), manager(s), and/or Sales Manager(s)who oversaw the Sales or Detail Representative, Medical Science Liaison, or Tele-detailer in the DPF or in response in response to Question B(1) above for the five years before Plaintiff's first FCM prescription through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF, regarding ferric carboxymaltose. If no Sales or Detail Representative is identified by the responding Defendant in the DPF or in response in response to Question B(1) above, identify by name and employer the Territory and District Manager(s) responsible for the territory covering the Healthcare Provider for the five years before Plaintiff's first FCM prescription through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF.

3. To the extent not previously produced with the DPF, produce:

   a. FCM call notes on each Healthcare Provider(s), and correspondence to each Healthcare Provider(s) from Sales or Detail Representatives, MSLs, or tele-detailers, within five years before the first prescription of Injectafer through and including the latest date in the "Approximate Date Range" as set forth in Section VI B of the PPF, regarding ferric carboxymaltose.

   b. Copies of or identify specific Bates reference(s) to any documents identified in the call notes that were shown or sent to each Healthcare Provider, identifying which document relates to which Healthcare Provider(s).

C. For each Prescribing Healthcare Provider(s) identified in section III of the PPF, state whether you have in your possession prescriber-level information reflecting, in whole or in part, the Prescribing Healthcare Provider's administrations of FCM, including but not limited to the number of administrations, in whole or in part, and the timeframe when FCM was administered. Yes ___ No ___

If yes, produce or identify by Bates range any documents showing the FCM administrations ordered by the Prescribing Healthcare Provider(s). *Plaintiffs understand and agree that Defendants cannot verify the accuracy and/or completeness of any data responsive to this request that was prepared by a third-party, and they reserve the right to object to the admissibility of any such data.*

III. INFORMATION REGARDING THE PLAINTIFF

A. Preceding the filing of Plaintiff's complaint, did responding Defendant perform or receive any non-privileged analysis or review of information, medical records, or medical/scientific information concerning Plaintiff, his or her use of FCM, and the potential that his or her injuries were related to FCM? This request does not ask the responding Defendant to reveal or produce privileged information, including but not limited to work product of attorneys or of experts who were retained for this litigation. Yes ___ No ___

If yes, identify the person(s) or department performing the analysis or review and produce and identify any documents related to the analysis.

If the responding Defendant is withholding responsive and otherwise discoverable documents based on privilege, the responding Defendant shall produce a privilege log pursuant to FRCP 26(b)(5).

B. Produce a copy of any Adverse Event Report that relates to Plaintiff and his or her use of FCM, as well as the related adverse event source file, including but not limited to causality assessments, medical records, and non-privileged investigative reports or analysis. C. Produce or identify by Bates number any non-privileged surveillance, information, investigation, report, or document concerning Plaintiff.

D. Excluding any expert opinions developed in connection with this litigation, if you contend that any person, entity, medical condition, food, medication, or product – other than the responding Defendant and Injectafer – is a cause of the Plaintiff's alleged injuries ("Alternate Cause"):

1. Identify the Alternate Cause with specificity.

2. Set forth the date(s) and mechanism of Alternate Cause.

3. Identify any non-privileged documents relating to this conclusion.

DEFENDANT'S CERTIFICATION

I am employed by _____, one of the Defendants in this litigation. I hereby certify that the information provided in the accompanying Defendant Fact Sheet is not within my personal knowledge, but the facts stated herein have been assembled by authorized employees and counsel, upon which I relied. I hereby certify, in my authorized capacity, that the responses to the Defendant Fact Sheet are true and complete the best of my knowledge and belief, and that I have engaged in best efforts to identify, locate, and support all of the documents requested in this DFS. I acknowledge that I have an obligation to supplement the above responses, in accordance with the Federal Rules of Civil Procedure, if I learn that they are in some material respect incomplete or incorrect.

Date: _____

Name: _____

Title: _____

Signature: _____